Primary Care Network

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1 SERVICES

The Primary Care Network serves a population not previously eligible for Medicaid. The Scope of Service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. Services in the office should comport with the definition of Primary Care found in Utah Administrative Code R414-100-2(3).

Verification

Qualified persons receive a yellow Primary Care Network Identification card.

1 - 1 Authority

The Primary Care Network is authorized by a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services and allowed under 42 CFR 4.35.1115, 2000-edition. This rule is authorized by Title 26, Chapter 18, Utah Code Annotated.

1 - 2 Definitions

1. "Client" means a person the Division or its duly constituted agent has determined to be eligible for assistance under the Medicaid program.

2. "CLIA" means the Clinical Laboratory Improvement Amendments of 1988.

3. "CMS" means the Centers for Medicare and Medicaid Services.

4. "Code of Federal Regulation" (CFR) means the publication by the Office of the Federal Register, specifically titled 42, used to govern the administration of the Medicaid program.

5. "Division" means the Division of Health Care Financing within the Department of Health.

6. "Emergency" means the sudden onset of a medical condition, traumatic injury or illness manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    a) placing the client's health in serious jeopardy;
    b) serious impairment of bodily functions;
    c) serious dysfunction of any bodily organ or part; or
    d) death.

7. "Emergency Department Service" means service provided in a designated acute care general hospital emergency department.

8. "Emergency Service" means:

    a) Attention provided within 24 hours of the onset of symptoms or within 24 hours of making a diagnosis;
    b) A condition that requires acute care, and is not chronic;
    c) It is reimbursed only until the condition is stabilized sufficient that the patient can leave the hospital emergency department; and
    d) It is not related to an organ transplant procedure.

9. "Outpatient" means a client who is not admitted to a facility, but receives services in a private office or clinic.

10. "Outpatient setting" means the physician's office.

11. "Primary Care" means services to diagnose and treat illness and injury as well as preventive health care services. Primary care promotes early identification and treatment of health problems, which can help to reduce unnecessary complications of illness or injury and maintain or improve overall health status.

12. "Primary Care Provider System" means those services provided directly by the physician or by his staff, under his supervision in the office.

13. "Provider" means any person, individual, corporation, institution or organization, qualified to perform services available under the Medicaid program and who has entered into a written contract with the Medicaid program.

1 - 3 Billing Clients

Effective July 1, 2002, providers who serve Primary Care Network patients may bill patients for non-covered services set forth in the Primary Care Network Manuals, Primary Care Network Information Bulletins, and letters to providers. A written agreement upon time of service is recommended, but not required.

2 SCOPE OF SERVICE

2 - 1 Physician Services

Physician services provide for the basic medical needs of eligible individuals and must be provided within the parameters of accepted medical practice. Physician services may be provided directly by the physician or by other professionals – licensed certified nurse practitioners, or physician assistants, authorized to serve the health care needs of the practice population through an approved scope of service under the physician's supervision.

Providers of Primary care service are limited to those physicians who are prepared in:
Family Practice,
General Practice,
Internal Medicine,
Obstetrics and Gynecology, and
Pediatrics.
In addition, providers of physician services in Federally Qualified Health Centers, Rural Health Clinics, Local Health Department clinics, and Health Clinics of Utah can provide service based on the Scope of Service and codes developed for the Primary Care Network program.

Physician services include those that can be performed in an outpatient setting.

1. The CPT Manual is the standard for defining and coding physician services. Under the provisions of this plan, not all procedures are acceptable, e.g., experimental, cosmetic, or those not reasonable, medically necessary or cost effective. Nonspecific or unlisted codes require physician review because of the potential for use to cover otherwise non-covered services.

2. The Approved Medical and Surgical Procedures for the Primary Care Network with Pertinent Criteria ("PCN - CPT Code List") is implemented into this program. This list serves as a guide as well as a safeguard to inappropriate utilization. The list outlines those procedures which are excluded because they are experimental, ineffective, cosmetic, or not reasonable and medically necessary. (List attached.)

3. The CPT office visit, Evaluation and Management codes (99201 - 99215) for either new or established patients are appropriate for the office services claims under this plan.

4. In general, both office visit and service codes will not pay for same dates of service.
   a) Modifier 25 Providers are advised to place the modifier 25 on evaluation and management codes only when procedures performed may include the evaluation and management service. A delay in payment is occurring when the modifier 25 is placed on claims which would automatically pay. For example, placing the modifier 25 on preventive evaluation and management codes 99385, 99386, 99395 and 99396 means that the claim is suspended for review. Usually codes for vaccines and the administration fee are the only other codes on the claim. The administration fee, vaccine fee, and E&M service will automatically pay without the modifier.
   b) Therapeutic procedures An evaluation and management code and a diagnostic procedure or therapeutic procedure code will generally not be covered separately on the same date of service. This includes service in the Emergency Room and outpatient service.
   c) Incidental procedures The new version of the editing program containing additional Correct Coding Initiative (CCI) edits will be brought on line in January 2006. Incidental edits occur when a procedure is considered an integral component of another procedure.

5. Licensed certified family or pediatric nurse practitioners are limited, under this Medicaid Scope of Practice, to a cooperative, ambulatory, office type, working relationship with a physician. When employed by the physician, the physician bills for the service.

6. Physician assistants work under the supervision of a physician to provide service to patients within the practice population.

7. Physicians providing service in the Emergency Department will use CPT Codes 99281 - 99285 to bill for services.

2 - 2 Limitations for Physician Services

1. The CPT Manual is the standard for defining and coding physician services. However, not all procedures are covered under this plan, e.g., experimental, ineffective, cosmetic, or those not cost effective, reasonable or medically necessary.
2. Use of nonspecific or unlisted codes to cover procedures not otherwise listed in the CPT Manual require Medicaid physician consultant review and approval because of the potential for use to cover otherwise non-covered services.
3. Services are limited to those included in the "PCN - CPT Code List" with criteria.
4. Evaluation/Management office visit codes (CPT) for new and a (99201 - 99215) must be used appropriately on claims for service.
5. Office visit codes (E/M) and service codes (10060 - 69990) will not be paid on the same date of service.
6. Services identified by the 90000 series of codes are specialty medical services and will be limited only to those that can be safely provided in the physician's office.
7. After-hours office visit codes cannot be used in a hospital setting, including emergency department, by private or staff physicians. They cannot be used for standby for surgery, delivery, or other similar circumstances, and they cannot be used when seeing a new patient.
8. Cognitive services are limited to one service per day by the same provider.
9. Modifier 25 will not be recognized as a stand-alone entity to override the one service per day limitation.
10. Laboratory services provided by a physician in the office are limited to the approved kits, waived tests or those laboratory tests identified by CMS for which an individual physician is CLIA certified to provide and listed in the "PCN -CPT Code List."
11. Unspecified laboratory codes will no longer be accepted when there is a specific test available. The specific test must be ordered to receive reimbursement. For example:

    The code 87660–Trichomonas vaginalis, direct probe, must be used; the code 87797–Infectious agent not otherwise specified; direct probe technique will no longer be accepted when the test completed is Trichomonas vaginalis, direct probe. This also applies to the Affirm Test. The code 87800–Infectious agent detection, direct probe technique will no longer be accepted when the test is Chlamydia trachomatis, direct probe. The code 87490–Chlamydia trachomatis, direct probe must be used.
12. A specimen collection fee is limited only to venipuncture specimens drawn under the supervision of a physician to be sent outside of the office for processing. Any blood test obtained by heel or finger stick will post a mutually exclusive edit with 36415 –venipuncture. The following codes have been added as mutually exclusive to 36415: 82948–blood glucose, reagent strip, 85013–spun hematocrit, 85014–hematocrit, 85610–Prothrombin time, 83036–glycated hemoglobin, and 86318 –immunoassay for infectious agent by reagent strip when submitted with the modifier QW.
13. Genetic counseling and genetic testing:

    The program does not cover testing completed for general population screening where there is no symptomatic evidence or family history of genetic disease, nor is screening covered for investigational or research purposes. Genetic screening tests are only considered for coverage when there is a significant family history of a treatable genetic disorder occurring within a three-generation family group sheet and the test is medically necessary for the patients care.

    If the physician reviews the family history and determines a medically necessary reason to complete cytogenetic testing in an adult, information must be submitted for medical review of coverage prior to completion of code 83914.
14. Over-the-counter drugs and medications are limited to those on the list of covered OTC drugs established for this plan. Refer to Chapter 2 - 6, Pharmacy Services, or the PCN Manual (Attachment Section).
15. Vitamins are limited to coverage for pregnant women. Vitamin B-12 is limited to patients with pernicious anemia.
16. Drugs and biologicals are limited to those approved by the Food and Drug Administration or the local Drug Utilization Review Board which has the authority to approve off label use of drugs.

    The pneumovax vaccine **must be separated by more than five years.** When given sooner than five years, there are adverse reactions which may occur from this vaccine. For updates on adult vaccination visit the Centers for Disease Control and Prevention web site at http://www.cdc.gov/nip/recs/adult-schedule.pdf
17. Additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration for additional reimbursement.
18. Medical and Surgical Procedures identified by CPT code may only be provided by the physician or osteopath. Procedures may not be completed by ancillary personnel including nurse practitioners and physician assistants.
19. Medical services provided by ophthalmologists or optometrists are limited to codes 92002, 92004, 92012, 92014, 92020, 92083, 92135, 99201- 99205, 99211-99215, S0620, and S0621.

2 - 3 Hospital Services

The Primary Care Network **does not cover** inpatient or outpatient hospital services except for emergency services in a designated acute care general hospital emergency department.

Revenue Codes and ICD.9.CM diagnosis codes are the main means of documentation for these services. Revenue Codes appropriate to be covered for emergency service are:

Emergency Room	450, 458, 459
Laboratory	300, 302, 305, 306, 309, 925, 929
Radiology	320, 324, 329
EKG/ECG	730, 739
Respiratory Therapy Services	410
Inhalation Therapy	412, 419
Cast Room	700,709
Observation/Treatment Room	760, 761, 762, 769
Pharmacy (medications used in ED)	250, 260, 269
IV Solutions	258
Med-Surg Supplies (use in ED only)	270

All other revenue codes are non-covered.

In addition, the current Medicaid Authorized Diagnoses for Emergency Department Reimbursement list is incorporated as approved emergency department care. Any code other than one of those listed would be a non-covered service resulting in no payment being made. If the determination is made that the visit is not for a bonafide emergency, and no service is provided, revenue code 458 (Triage fee) can be billed and a nominal payment can be made to the hospital for the evaluation and determination. The diagnoses in the Authorized Emergency Department list are ICD.9.CM codes. (List Attached.)

Physicians providing service in the Emergency Department will use CPT Codes 99281 - 99285 to bill for services.

1. Observation services are limited to cases where time is needed for observation and evaluation to establish a diagnosis and/or the appropriateness of an inpatient admission.

   Observation services are defined as use of a bed and periodic patient monitoring, on the hospital's premises, by hospital nursing or other appropriate staff. Observation services are considered reasonable and medically necessary when needed to evaluate an outpatient's condition and assess the need for possible inpatient admission. Observation services are covered only under physician's written orders.
   [Taken from UB-92 Billing Instruction Manual.]
   Observation Services, under Medicaid, are limited to 24 hours or less.

Coverage

1. Observation may be appropriate when:

2. A patient arrives at the facility in an unstable condition with vague symptoms which do not point to a definitive diagnosis. Observation and testing are indicated to identify the nature of the complaint and establish a treatment plan.

3. An unusual reaction follows an outpatient surgical procedure and requires monitoring or treatment beyond that customarily provided in the immediate post operative period, i.e., a drug reaction; delayed recovery from anesthesia; or acute pain unresolved by usual medication administration.

4. A significant, adverse reaction, above and beyond the usual response expected as a result of a scheduled diagnostic test or outpatient therapeutic services.

Observation Service must be medically necessary, and the following criteria and guidelines must be met:

- Reason for observation must be stated in the physician's orders for observation

- Patient's condition is clinically unstable as characterized by:

  ✓ Variance from generally accepted, safe laboratory values, or
  1. Clinical signs and symptoms above or below those of normal range which indicates need for evaluation and monitoring, or
  2. Uncertain severity of illness or condition exists. Change in status is anticipated and immediate medical intervention may be needed.

- Laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization.

- Diagnosis and treatment plan are undefined until further evaluation is completed.

Documentation in the medical record must support the medical necessity of observation services and justify the amount of time spent in observation. Documentation must include, but is not limited to:

The written physician's order
The differential diagnosis(es)
Signs and symptoms; vital signs; lab values, etc.
Documented complications
Recorded observations and interventions (tests, x-rays, EKG, etc.),
Findings/Response to interventions
Interval assessments and charting
Status change - improvement/deterioration
Recorded time in and time out

Limitations

- Observation services must be patient specific and not part of standard operating procedure or facility protocol for a given diagnosis or service.

- Use of observation status to submit ancillary charges associated with outpatient surgery, other outpatient diagnostic services, or other outpatient stays for any reason is excluded from reimbursement.

- Observation services are limited only to those provided under orders specifically written by the physician or other provider authorized to admit patients to the hospital or to order outpatient tests. Reason for the observation service must be clearly stated in the order.

- Observation services are not covered for the convenience of the hospital, physicians, patients, or patient's families or while awaiting placement in another health care facility.

- Observation services are limited to 24 hours or less total time. An outpatient procedure -- surgical and/or diagnostic, which becomes an observation because of a complication or an adverse reaction must meet the 24 hour limitation. As the 24 time limit approaches, the need for admission or discharge must be determined through use of the Medicaid agency standard criteria, if applicable, or through severity of illness and intensity of service criteria.

- When a patient is admitted to the hospital at the end of the observation period, observation services are rolled into the admission DRG.

- Observation services can not be covered or billed for routine preoperative preparation associated with an outpatient surgery. These services are included as part of the surgical procedure and do not warrant additional payment.

- Observation services can not be covered or billed for the routine preparation time before a scheduled invasive outpatient diagnostic procedure or the recovery period following the procedure. For most procedures, this time is included in the procedure itself.

- Scheduled ongoing therapeutic services associated with a known medical condition include a required period of time to evaluate response to the service. This period of evaluation is not a separate observation service and must not be billed as such.

- Outpatient administration of blood or IV fluids associated with no other medical treatment does not qualify as an observation service. The use of the hospital facilities, including staff time, is inherent in the administration of the blood or fluids and is included in the payment for the administration of the blood or fluids.

- Outpatient services for dressing changes, IV administration or medication administration as follow-up care related to a surgical procedure and within the normal recovery period following surgery (42days) are the responsibility of the surgeon, and do not qualify as separate hospital observation or treatment services.

- Units are not required for billing or payment of observation services. The important parameters are a clear recording of admission time and discharge time along with detailed recording of services provided during the observation time.

- Under no circumstances can an observation stay be extended to more than 24 hours. It is not expected that a patient would be discharged in the event the 24 hour time limit would be reached after midnight or into the early morning hours, but the additional time does not warrant an additional day stay.

Exception

There are circumstances in which a patient is admitted to inpatient service with the intent of remaining more than 24 hours and later improves to the point discharge is indicated. The stay may be covered and billed as Observation providing all criteria for observation admission are met, including the hospital admission order, and documentation in the medical record is consistent with that noted above as justification and support of medical necessity for observation.

2 - 4 Minor Surgery and Anesthesia in an Outpatient Setting

For the purposes of this program, outpatient setting means only in the physician's office. Only those procedures that can be safely provided in the physician's office can be covered.

2 - 5 Laboratory and Radiology Services

Professional and technical laboratory and radiology services are furnished by certified providers with use of the 70000 and 80000 series of codes.

1. For this program, laboratory and radiology procedures will be limited to those which can be provided through the "Primary Care Provider system," i.e., in the physician's office.

2 Laboratory services are limited under federal CLIA regulations. All laboratory testing sites providing services must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Only laboratories CLIA certified can complete certain tests and receive payment. (PCN CLIA List attached.)

3. Some laboratory and radiology procedures are non-covered because they relate to otherwise non-covered services. The "PCN -CPT Code List" indicates covered service.

4. CPT code 80074, acute hepatitis panel, includes four other codes: 86709, 86705, 87340, and 86803. When three of the four codes are billed, they will be rebundled into the acute hepatitis panel code 80074 for payment.

5. Digital mammography add-on code 76082 and code 76083 are covered strictly for coding purposes. The CPT manual instructs the provider to submit the add-on code 76082 or 76083 with the code for standard mammography, and code 76090 or 76091 or 76092 to indicate digital mammography was completed. The add-on codes 76082 and 76083 will be opened in the reference file for coding purposes to pay zero, beginning January 1, 2005. The provider may complete standard or digital mammography. However, PCN will continue to pay the reimbursement rate for standard mammography.

6. Allergen Immunotherapy Testing: The code 86003–Allergen specific IgE will require submission of medical record documentation to support medical necessity of IgE testing. This service should not be a screening method for allergy. Skin patch testing is the standard of care. Providers billing with code 86003 must include documentation of the history of the suspected allergy, duration, severity, results of other allergy tests, and previous treatment of the disorder and an attachment to support the medical necessity of the IgE testing including at least one of the following:

    - Direct skin testing is impossible due to infancy, extensive dermatitis or the patient has marked dermatographism.
    - Patient is unable to discontinue medication (i.e. tricyclic antidepressant, prednisone, or beta blocker, antihistamine) that interferes with skin testing.
    - Direct skin testing is negative despite clinical indications of an allergic condition and specific IgE tests have been determined.

    The testing will be reimbursed only for testing of suspected allergens. Use as a multiple allergy screening tool is not covered. An initial allergy screen is twelve tests. Coverage will be limited to one panel with a unit limit of 12 tests. If all tests are negative, an additional testing beyond the initial 12 tests is not considered medically necessary.

2 - 6 Pharmacy Services

The Medicaid Pharmacy Policy as set forth in the Utah Provider Manual for Pharmacy Services is hereby adopted for the Primary Care group of clients with the following changes. Coverage is more restrictive for units and time.

Pharmacy services include prescribed drugs and preparations provided by a licensed pharmacy. The fact that a provider may prescribe, order, or approve a prescription drug, service, or supply does not make it an eligible benefit, even though it is not specifically listed as an exclusion. The following pharmacy benefits and restrictions are incorporated into this program.

1. Drug Limitations and Benefits

   A. This program is limited to four prescriptions per month, per client with no overrides or exceptions in the number of prescriptions.
   B. OTC prescriptions count against the 4RX/month limit.
   C. A patient paid prescription is not counted as one of the four prescriptions per month.
   D. The copay is product dependent:
      (1) $5.00 copay for any generic product.
      (2) $5.00 copay for the preferred drugs on the attached list.
      (3) $5.00 copay for OTC products.
      (4) 25% of the Medicaid payment for any name brand drug not on the preferred list where a generic product is NOT available.
      (5) 25% of the Medicaid payment for any product that is in the same therapeutic class as a product on the Preferred Drug List.
   E. When a generic product is available and the name brand is requested and the name brand is NOT on the preferred list, the total payment must be made by the client.
   F. Prior approval and the criteria governing such are the same as the regular Medicaid program.
   G. Generic drugs with an A B rating are mandated for dispensing.
   H. Name brand drugs where generics are available will require full payment by the client. No physician DAW is available.
   I. Over-the-counter products. The extent of these products is more limited than regular Medicaid. Products covered are: Insulin 10cc vials; Insulin syringes; glucose blood test strips; lancets; contraceptive creams, foams, tablets, sponges, and condoms.
   J. OTC products that are covered require a written prescription just like legend drugs in order for the pharmacy to fill them.

2. Exclusions and Restrictions

   A. No duplicate prescription will be paid by Medicaid for lost, stolen, spilled or otherwise non usable medications.
   B. No injectable products are available for payment by Medicaid except for 10 ml vials of Insulin.
   C. Compounded prescriptions are not covered.
   D. Drugs are covered for labeled indications only.
   E. Rapidly dissolving tablets, lozenges, suckers, pellets, patches, or other unique formulations or delivery methodologies are NOT available, except where the specific medication is unavailable in any other form (Duragesic and Actiq - see chapter 2-6.3, Cumulative amounts). Patches are NOT reimbursable.
   F. Cosmetics, weight gain or loss products are not covered.
   G. No vitamins or minerals are covered, except for pregnant women.
   H. Drugs for Erectile Dysfunction are not covered as of January 1, 2006, per Federal Law change.

3. Cumulative monthly amounts are determined for the following drugs:

   a. Celebrex - 60
   b. Bextra - 30
   c. Muscle relaxants - 30 (baclofen, tizanidine, and dantrolene not included)
   d. Sedative-Hypnotics 30
   e. Oral APAP/narcotic combinations -180
   f. Methadone, any strength - 150
   g. Actiq - 120
   h. Duragesic 25, 50, & 75 mcg - 15
   i. Morphine long acting formulations, any strength - 90
   j. Oxycontin or generic, any strength - 90
   k. PPIs - 31 with prior approval for override.
   l. Stadol NS - 10 ml (4 vials)
   m. Tryptans (for migraine headache) - 9
   n. Ultram and generics - 180
   o. Ultracet 180 (focus on APAP, therefore included in oral APAP/narcotic 180 cumulative limit)
   p. Miralax - 1054 gm
   q. Lactulose - 1800 ml
   r. Short-acting single agent opiod analgesics - 180
   s. Benzodiazepines - 120 (April 1, 2006)
   t. Diphenoxylate containing preparations - 180
   u. Butalbital containing preparations - 30
   v. Spiriva® - 30

4. Drugs Requiring Prior Approval:

   Drugs on the current PCN Drug Criteria and Limits List require prior approval. List attached.

2 - 7 Durable Medical Equipment and Supplies

Equipment and appliances are necessary to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment. However, the Primary Care Network waiver notes that "The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion."

The following codes represent covered equipment and supplies under this plan:

A4259; A4565; A4490 - A4510; A4253; E0114; E0135 LL; A4570; A4614; E1390RR; K0001 LL; L0120; S8490.

2 - 8 Preventive Services and Health Education

The Primary Care Network includes preventive screening services, including routine physical examinations and immunizations, and educational methods and materials for promoting wellness, disease prevention and management.

Effective July 1, 2005, **one** comprehensive preventive health examination is covered per calendar year. The initial code 99385 or 99386 may be billed once for an annual examination, in subsequent years code 99395 or 99396 should be billed.
These services are assumed under the general Evaluation and Management care provided to patients by the physician during medical visits. The services include counseling, anticipatory guidance, and/or risk factor reduction interventions. Except for immunization codes, no special programs or codes are covered. The intent is that these services be billed under the general evaluation and management codes and a co-pay should be collected.

Diabetes: Effective January 1, 2004 using code S9455 – Diabetes Self-Management Training Program will be available for use by authorized diabetes self-management providers. Patient preauthorization is required to receive diabetes self-management training.

Patient Preauthorization**:**
A newly diagnosed patient with Type I, Type II, or gestational diabetes or a patient previously diagnosed with Type I or Type II diabetes, is eligible to receive diabetes self-management training through Medicaid when:

- The physician provides a referral for the patient who has never had a diabetes self-management training course. The course is limited to ten sessions.
- The patient completed the diabetes training at least 12 months ago, and the physician refers the patient for a specified number of refresher diabetes training sessions because:
  - The patient has progressed in diabetes illness to require further management training or the patient has indications they are noncompliant with treatment.
  - Patient has complications of diabetes requiring two or more visits to the emergency room during the last six months or a hospital admission related to diabetes within the last year.

At preauthorization the following patient information should be provided:

- Patient is informed of the importance of completing the series of classes and agrees to sign a contract agreement to make every attempt to follow through with education sessions.
- The patient is informed that if they do not complete the classes there is a one year waiting period before further classes will be authorized.

Authorized Providers:

- Diabetes self-management training must be provided through a state or nationally recognized program.
  - As required by CMS, the Diabetes Self-Management Program must be taught by a state licensed RN, certified dietician, and registered pharmacist. At least two of the three provider types are required to apply to Medicaid as a Diabetes Self-Management program and obtain a provider group practice number. Providers who may become recognized for reimbursement include an ADA certified diabetes educator (CDE) or a Utah State Department of Health certified instructor.
  - A Utah State Department of Health certified instructor must have completed a minimum of 24 hours of recent approved diabetes specific continuing education which covers the ADA 15 core curriculum content areas. At least 6 hours of diabetic specific continuing education must be completed each year following the completion of the initial 24 hours by each instructor or certified diabetes educator in the program.
  - Each instructor (RN, pharmacist, or dietician) must be qualified to teach all of the 15 core content areas.

Immunizations:

90471 - 90473 Administration fee

Covered Immunization Agents:

90740 Hepatitis B vaccine for immunocompromised adult or adult dialysis patient
90746 Hepatitis B adult
90632 Hepatitis A adult
90636 Hepatitis A and Hepatitis B combination for adult
90658 Influenza virus vaccine, split virus, 3 yrs+, intramuscular
90718 Tetanus and diphtheria toxoids (Td) This should be main choice because of resurgence of diphtheria in Europe.
90703 Tetanus toxoid
90675 Rabies IM for post exposure treatment
90707 MMR vaccine
90713 Poliovirus vaccine, inactivated, (IPV), subcutaneous or intramuscular
90714 Tetanus and diphtheria toxoids (Td) absorbed, preservative free, intramuscular
90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaPp), intramuscular
90716 Varicella for subcutaneous use for a varicella-exposed person who is not immune, but not for use in immunocompromised patient.
90732 Pneumococcal polysaccharide 23-valent vaccine adult or immunosuppressed patient
90665 Lyme disease only if known exposure.

Note: The initial pneumovax vaccination is sufficient for most people. For those patients with rare conditions which require revaccination, only one additional vaccination for pneumovax is recommended. It must be given at least 5 years from the initial vaccination to prevent adverse reactions. PCN pays for one influenza vaccination annually. The National Immunization Program at Centers for Disease Control and Prevention states that an additional influenza vaccination is not recommended. For updates on current adult vaccination recommendations and issues visit the CDC web site at http://www.cdc.gov/nip/recs/adult-schedule.pdf

2 - 9 Family Planning Services

This service includes disseminating information, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. All services must be provided or authorized by a physician, or nurse practitioner and must be provided in concert with Utah law. Refer to Chapter 2 - 17, Non Covered Services under the Primary Care Network.

2 - 10 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice. Covered services are limited to:

1. Examinations and refractions. No glasses will be covered.
2. One exam every 12 months.

The following codes are covered: 92002, 92004, 92012, 92014, S0620, and S0621. The examination fee includes the refraction (glasses prescription).

2 - 11 Dental Services

Services include relief of pain and infection for dental emergencies limited to an emergency examination, an emergency x-ray, and emergency extraction when the service is provided by a dentist in the office. Only the following dental codes are covered:

D0120 Periodic exam - 2 per year, no sooner than 6 months apart
D0140 Limited exam, focused problem (emergency examination)
D0150 Comprehensive oral exam, one per provider
D0210 Intra oral complete series - including bitewings, total of 8 or more films
D0220 Periapical x-ray 1 film
D0230 Periapical x-ray additional film
D0270 Bitewing single
D0272 Bitewing 2 films
D0274 Bitewing 4 films
D1110 Adult prophy
D1205 Topical fluoride application
D4355 Debridement for diagnosis - instead of prophy, one per year
D2140 Amalgam 1 surface permanent
D2150 Amalgam 2 surface permanent
D2160 Amalgam 3 surface permanent
D2161 Amalgam 4+ surface permanent
D2330 Resin 1 surface anterior
D2331 Resin 2 surface anterior
D2332 Resin 3 surface anterior
D2335 Resin 4+ surface anterior
D7140, Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
D7210 Extraction surgical, document need to lay flap, section tooth

2 - 12 Transportation Services

Ambulance (ground and air) service for medical emergencies only.

The following codes are covered.
A0425, A0429, A0430, A0431.

2 - 13 Interpretive Services

Services **provided by entities under contract to Medicaid** to provide medical translation service for people with limited English proficiency and interpretive services for the deaf.

No specific codes are identified. When providers use the Medicaid authorized interpretive services, payment is made to the entity under terms of the signed contract. Medical providers may use their own interpreters. However, independent interpreters cannot bill nor be paid by Medicaid. If independent interpreters are used, payment remains the responsibility of the provider who secured their services.

2 - 14 Audiology Services

Audiology services are limited to one hearing test for hearing loss annually.
V5010, assessment of hearing aid.
Hearing aids are not a covered benefit.

3 Non-Covered Services under the Primary Care Network

1. Inpatient or outpatient hospital diagnostic, therapeutic, or surgical services, except for those in the emergency department or those very minor procedures which can be provided in the physician's office.

2. Procedures that are cosmetic, experimental, investigational, ineffective or not within the limits of accepted medical practice.

3. Health screenings or services to rule out familial diseases or conditions without manifest symptoms.

4. Routine drug screening.

5. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, or for insurance or employment examinations.

6. Non-emergency ambulance service through common or private aviation services.

7. Transportation service for the convenience of the patient or family.

8. Family planning services - Non-covered:

   – Norplant: CPT procedure codes 11975, 11976, 11977

   – Infertility studies and reversal of sterilization:
   ICD.9.CM Diagnosis Codes: Male - 606.0 - 606.96
   CPT Procedure Codes: 54240, 54250, 54900, 54901, 55200, 55300, 55400.

   ICD.9. CM Diagnosis Codes: Female - 256.0 - 256.9; 628.0 - 628.9
   CPT Procedure Codes: 58345, 58350, 58750, 58752, 58760, 58770

   – Assisted Reproductive Technologies (ART's) (in-Vitro)
   ICD.9.CM diagnosis code: V26.1 and above infertility diagnosis codes.
   ICD.9.CM procedure codes: 66.1, 66.8, 69.92, 87.82, 87.83.
   CPT procedure codes are: 58321, 58322, 58323, 58970, 58974, 58976, 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89321

   – Genetic Counseling
   ICD.9.CM diagnosis code: V26.3, V65.40, V25.09
   CPT Procedure codes for cytogenetic studies: 88230 - 88299

9. Abortion

10. Sterilization

11. Weight loss programs

12. Office visit for allergy injections or other repetitive injections - Non-covered:

   – CPT procedure codes 95115 through 95134

   – CPT procedure codes 95144 through 95199

13. Vitamins - prescription or injection

14. Physical Therapy

15. Occupational Therapy

16. Massage Therapy - Non-covered:

    – CPT Procedure code 97124

17. Podiatric (podiatry) Services - Routine foot care

18. Stage Renal Disease (Dialysis)

19. Medical and surgical services of a dentist

20. Organ Transplant Services

21. Charges incurred as an organ or tissue donor

22. Home Health and Hospice Services
    This exclusion applies regardless of whether services are recommended by a provider and includes the following:
    Skilled Nursing Service
    Supportive maintenance
    Private duty nursing
    Home health aide
    Custodial care
    Respite Care
    Travel or transportation expenses, escort services, or food services

23. Mental health

24. Substance abuse and dependency services

25. Hypnotherapy or Biofeedback

26. Long Term Care

27. HIV Prevention

28. Home and Community-based Waiver services

29. Targeted case Management

30. Other outside medical services in free standing centers – Emergency centers (Insta-Care type), surgical centers, or birthing centers

31. Services to children (CHEC)

32. Chiropractic Services

33. Speech Services

Note: Any ICD.9.CM diagnosis or procedure codes related to any of the services in the preceding PCN *Non-Covered Services List* will also be non-covered. Payment of such services will be denied.

34. Pregnancy Related Services

A. Prenatal Services

59000	Amniocentesis; diagnostic	59001	Amniocentesis; therapeutic
59012	Cordocentesis	59015	Chorionic villus sampling
59020	Fetal stress test	59025	Fetal non-stress test
59030	Fetal scalp sampling	59050 - 59051	Fetal monitoring during labor
59100	Hysterotomy (Reqs PA)	59120 - 59121	Ectopic pregnancy
59130	Abdominal pregnancy	59135 - 59136	Interstitial pregnancy
59140	Cervical pregnancy	59150 - 59151	Ectopic pregnancy (Laparoscopy)
59320 and 59325	Cerclage of cervix	59350	Hysterorrhaphy

B. Vaginal Delivery, Antepartum, and Postpartum care

59400	Global delivery	59409	Delivery only
59410	Delivery with postpartum care	59412	Version
59414	Delivery of placenta	59425 - 59426	Antepartum care only
59430	Postpartum care only	59300	Episiotomy
59160	Postpartum D&C		

C. Cesarean Delivery

59510, 59514, 59515, and 59525 hysterectomy following delivery (emergency)

D. Delivery after Previous C-section

59610, 59612, 59614, 59618, 59620, 59622

E. Abortions and Sterilizations

55250	55450	55530	55535	55540	55550	55600	55605	55650	58563	58600	58605
58611	58615	58661	58670	58671	59100	59840	59841	59850	59851	59870	59852

F. Other pregnancy related medical procedures

59866	Multi fetal pregnancy reduction	59870	Molar pregnancy
59871	Removal of cerclage suture	59898	Unlisted services/procedures
59899	Unlisted services/procedures		
76805 - 76828	Ultrasounds		

G. High Risk and Enhanced Services

H1000 and H1001 Risk Assessment

H. High Risk Delivery(s)

59400 (22 modifier) Global (vaginal)
59510 (22 modifier) Global (C-section)
59410 (22 modifier) Delivery and Postpartum care only
59515 (22 modifier) C-section and Postpartum care only

I. Enhanced Services - **These are the services added under the “Baby Your Baby” Program and are non-covered in PCN.

T1017, H1004, S9446, S9470, H0046
Single Visits 99204-SB and 99212-SB

J. Certified Nurse Midwife Services

CNM services are not covered in PCN. Well-Woman Care and Contraceptive Management are only covered when provided by a participating primary care provider.

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